BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

DOUGLAS C. RICHARDS	)	
Claimant	)	
VS.	)	
	)	Docket No. 170,134
COASTAL EMERGENCY SERVICES OF	)	
ST. LOUIS, INC., and MEDICAL GROUP	)	
PURCHASING ASSOCIATION	)	
Respondents	)	
AND	)	
	)	
ST. PAUL GUARDIAN INSURANCE and	)	
LIBERTY MUTUAL INSURANCE COMPANY	)	
Insurance Carriers	)	
AND	)	
	)	
KANSAS WORKERS COMPENSATION FUND	)	

ORDER

Claimant appeals the February 16, 2004 Award of Administrative Law Judge Robert H. Foerschler. Claimant was denied benefits after the Administrative Law Judge (ALJ) determined that claimant failed in his burden of proving that he was an employee of respondent, but was instead an independent contractor, and further that the medical evidence did not directly connect his current condition with the injuries allegedly sustained while employed with respondent. The Appeals Board (Board) heard oral argument on October 12, 2004.

APPEARANCES

Claimant appeared by his attorney, James R. Shetlar of Overland Park, Kansas. Respondent and its insurance carrier, Liberty Mutual Insurance Company, appeared by their attorney, James K. Blickhan of Kansas City, Missouri. Respondent and its insurance carrier, St. Paul Guardian Insurance, appeared by their attorney, Katharine M. Collins of Overland Park, Kansas. Respondents Coastal Emergency Services of St. Louis, Inc., and Medical Group Purchasing Association appeared by their attorney, Dennis L. Horner of

Kansas City, Kansas. The Kansas Workers Compensation Fund appeared by John A. Bausch of Topeka, Kansas (appearing for Bruce D. Mayfield of Overland Park, Kansas).

RECORD AND STIPULATIONS

The Board has considered the record and adopts the stipulations contained in the Award of the Administrative Law Judge. Additionally, the parties acknowledge that if this matter is reversed and claimant found to be an employee for workers compensation reasons, the matter should be remanded to the ALJ for consideration of numerous issues which were not determined by the ALJ at the time of the original award.

Additionally, the Board notes the proceedings filed in the United States Bankruptcy Court for the District of Maryland (Baltimore Division), in Case Nos. 02-6-7576 (SD) through 02-6-7815 (SD), regarding Baltimore Emergency Services, et al., in a Chapter 11 bankruptcy filing. Coastal Emergency Services of St. Louis, Inc., and Medical Group Purchasing Association are both legal entities involved in that Chapter 11 bankruptcy, which normally stays further proceedings in workers compensation litigation subject to 11 U.S.C. § 362 (2000). It is the claimant's responsibility to see that any stay in effect is lifted in order for a workers compensation claim[1] to proceed. In this matter, the Consent Order Modifying the Automatic Stay was obtained by the parties effective September 26, 2003, and this matter will, therefore, proceed accordingly, with the automatic stay provisions of the United States Bankruptcy Code having been lifted.

ISSUES

(1) Was claimant an employee of respondent or an independent contractor on the date of accident?

(2) Did claimant suffer an accidental injury arising out of and in the course of his employment with respondent? If so, did claimant suffer an intervening injury which would abrogate respondent of any responsibility for providing ongoing benefits for the alleged injury?

(3) Did claimant provide timely notice of accident?

(4) Did claimant provide timely written claim of accident?

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[1] *Miner v. CX Transportation*, No. 248,286, 2003 WL 22401243 (Kan. WCAB Sept. 30, 2003), and *Trim v. CX Transportation*, No. 237,425, 2003 WL 22401239 (Kan. WCAB Sept. 30, 2003), aff'd by the Kansas Court of Appeals in *Miner v. CX Transportation*, 33 Kan. App. 2d 106, ___ P.3d ___ (2004).

(5) Does Liberty Mutual Insurance Company have coverage for injuries suffered from employment relationships generated in the state of Kansas and over litigation in workers compensation claims filed with the Workers Compensation Division in the state of Kansas?

(6) Did St. Paul Guardian Insurance (St. Paul) have coverage over claimant or was the workers compensation policy provided by St. Paul limited to clerical workers only?

(7) Is claimant prohibited from obtaining benefits in this matter pursuant to *Boucher*?[2]

(8) Is the independent medical report of Revis C. Lewis, M.D., dated April 25, 1997, admissible and part of the record pursuant to K.S.A. 44-516 or is it excluded from the record pursuant to K.S.A. 44-519?

(9) Does estoppel apply?

(10) What is the nature and extent of claimant's injury and/or disability?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant entered into a contract with respondent Coastal Emergency Services of St. Louis, Inc., later known as Medical Group Purchasing Association, (hereinafter "Coastal"), on July 1, 1989, with the contract actually being signed on September 29, 1989. At the time the contract was signed, claimant and respondent acknowledged claimant was working as an independent contractor to be placed by Coastal in various hospitals in the midwest to work as an emergency room physician. Claimant acknowledged that the contract specified that he was an independent contractor and further agreed that he understood the term, as claimant had, prior to medical school, attended and graduated from law school and had worked in private practice as a lawyer for several years in the Topeka area.

Claimant was working for respondent at Research Belton Hospital in Belton, Missouri, on August 8, 1991, when, while trying to lift a gurney, he felt a twinge in his low back. This twinge did not immediately cause significant pain or problems, but did slowly worsen until by the next day, he had pain through his buttock and thigh and down to his left foot. That weekend, claimant contacted Coastal in St. Louis, Missouri, advising that he had injured his back while working at Research Belton Hospital. He was scheduled to work

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[2] *Boucher v. Peerless Products, Inc.*, 21 Kan. App. 2d 977, 911 P.2d 198, *rev. denied* 260 Kan. 991 (1996).

at a hospital in Dodge City, Kansas, on August 12, 1991, but advised he was unable to do so because his back hurt too much for him to drive. Claimant testified he missed a 12-hour shift, but that is all the work he missed at that time. Claimant later testified that he eventually missed more time, having to limit his hours because of his ongoing back problems. This testimony by claimant is uncontradicted.

Claimant sought treatment with orthopedic surgeon Jon M. McMillan, M.D., and was provided with a back brace, muscle relaxants and pain medication. A CT scan was performed on August 13, 1991, which indicated mild bulging of the disc at L4-5, but displayed no abnormalities at L5-S1 and made no mention of any problems in the thoracic spine. However, there is some indication in the record that the CT scan was only of the lumbar spine, but this is not clear.

Claimant continued working for respondent at various locations, including Belton, Missouri, and Dodge City, Kansas, but, as noted above, he began working at a slower pace in the emergency rooms and working fewer hours per week. Claimant testified that in the year before his 1991 accident, he worked from 50 to 60 hours a week consistently, but there were periods thereafter when he worked only 24 to 36 hours per week because of back pain.

In November 1993, claimant was notified that his contract with Coastal was terminated, and he last performed services for Coastal in November 1993.

The terms of this contact, when initially entered, required claimant to work a certain number of hours per month for Coastal, in the range of 168 to 192, but did not require that claimant be exclusive to Coastal. Claimant had the right, and did, on numerous occasions, exercise the right, to work as an independent physician for other medical facilities.

Coastal provided no equipment or materials for claimant's use. The various hospitals to which claimant was referred and the facilities where claimant performed the health care services would provide the medical supplies and medical equipment, with claimant providing some of the materials, including his lab coat, stethoscope and scrubs. The specific policies of each hospital varied from facility to facility, with claimant being advised by each hospital to which he was referred as to the specific procedures to be followed.

It was acknowledged by claimant and by Wayne Ritchie Tilson, M.D., an emergency room physician, who had, at one time, worked for respondent, that a doctor's ability to work at a hospital was to be determined by the hospital. Likewise, whether a physician was to be fired or asked to leave was up to the local hospital, as the continued employment decision was exclusively the hospital's determination. Dr. Tilson advised that on the whole, emergency room physicians are an independent lot, with a specific practice style of their own, because they like to work independently, working their own shifts, in their own areas,

and making their own determinations. The actual medical determinations to be made were made by the health care physicians, rather than by the hospital or by respondent.

After claimant was treated by Dr. McMillan, he was next treated by board certified orthopedic surgeon David J. Clymer, M.D., who examined claimant on September 28, 1993. Dr. Clymer had the opportunity to review the CT scan from 1991, noting prominence of the disc at L4-5, with slight bulge and slight asymmetry towards the left side. He recalled no specific abnormalities at L5-S1, nor does he recall claimant making any complaints whatsoever to his thoracic spine. He reviewed the medical reports of Revis C. Lewis, M.D., John A. Pazell, M.D., Mercy Hospital, Newman-Young Clinic, Dr. McMillan, Dr. M. G. Knapp and Dr. Bill Hughes, and the Humana Dodge City Hospital. Ultimately, Dr. Clymer assessed claimant a 3 percent impairment to the body as a whole. The doctor's report makes no indication as to which edition of the AMA *Guides*[3] was used, but Dr. Clymer testified he probably used the Third Edition, Revised, although he acknowledges there is nothing in his report which specifies the specific edition. It is noted K.S.A. 44-510e(a) (Furse 1993), the version in effect at the time of the doctor's examination, stated in part,

> Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the third edition, revised, of the American Medical Association Guidelines for the Evaluation of Physical Impairment, if the impairment is contained therein.[4]

However, the 1991 version of K.S.A. 44-510e, in effect at the time of claimant's injury, stated in part,

> Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence.[5]

There were also several comments made by Dr. Clymer regarding various non-work-related injuries suffered by claimant, including a fall sustained in a Pizza Hut in February 1994 (which Dr. Clymer acknowledged was the kind of trauma which would cause a progression of claimant's radiographic findings), an injury in March of 1994 sustained while claimant was playing football with his son and another fall in March 1994 suffered by claimant on his wedding night when he injured his back. Again, these are the kinds of

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[3] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment*.

[4] K.S.A. 44-510e(a) (Furse 1993).

[5] K.S.A. 1991 Supp. 44-510e(a).

traumas which Dr. Clymer felt could cause progressive findings on radiographic studies, additional symptoms and additional restrictions of range of motion.

While Dr. Clymer examined claimant in September 1993, his deposition was not taken until August of 2001. He, therefore, had available a multitude of other medical reports which he reviewed prior to his deposition. This included an MRI performed in May of 1994, after the various above described accidents suffered by claimant. The MRI report in May of 1994 indicated not only an abnormality at L4-5, but also at L5-S1, which Dr. Clymer found to be a new finding not present at least prior to the MRI of May of 1994. Numerous objections were lodged by the various attorneys, specifically claimant's attorney, to the utilization by Dr. Clymer of the medical reports and records of the various health care providers who had earlier provided treatment for claimant. The objections, pursuant to K.S.A. 1991 Supp. 44-519, argued that none of the medical reports of the various doctors should be admitted, as none, except Dr. Pazell, Dr. Clymer and P. Brent Koprivica, M.D., actually testified in this matter. The Board notes, however, that the report of Dr. Lewis was pursuant to an order by the ALJ for an independent medical examination under K.S.A. 44-516 and is, therefore, a part of this record.

Claimant was examined by John A. Pazell, M.D., board certified orthopedic surgeon, on April 2, 1996, at the request of claimant's attorney. Dr. Pazell also reviewed various medical reports which he utilized in generating his opinion regarding claimant's ongoing condition. He found based upon the evaluation of the records and his examination of claimant, claimant had suffered a 34 percent whole person impairment, but acknowledged if he utilized the AMA *Guides* (3rd ed. rev.), the rating would be 33 percent to the body.

At the time of his examination of claimant, Dr. Pazell found absent ankle reflex, decreased sensation in the dermatome of the S1 level on the left side, weakness in the ankle and foot, and an inch of atrophy on the left calf. He found these to be consistent with the mechanics of trauma claimant had described, that being, lifting someone on a gurney. However, Dr. Pazell was advised of claimant's multiple falls in 1994, including the fall occurring on claimant's wedding night when he suffered injury to his left hip; the fall suffered while playing football with his son, also in 1994, which caused him to see Dr. Knapp; and a fall while claimant was at a rodeo when he was bumped by a calf, which caused him to return to Dr. Knapp in March 1994. Dr. Pazell acknowledged that when Dr. Clymer saw claimant in September 1993, there was no atrophy, but when Dr. Pazell saw him in 1996, there was atrophy of the left calf. Dr. Pazell testified that it would take anywhere from four to possibly nine months for the atrophy to develop. He also acknowledged that the types of non-work-related falls described were the types of injuries which could cause claimant's condition to worsen and could even be sufficient to herniate a disc.

Coastal also took the testimony of Wayne Ritchie Tilson, M.D., an emergency room physician, who had worked for Coastal in a situation very similar to that of claimant.

Dr. Tilson is board certified in emergency medicine and was currently practicing in Emporia, Kansas, and affiliated with Coastal. Dr. Tilson was acquainted with claimant when claimant was at Belton and Research Medical Center *[sic]*,[6] as Dr. Tilson was the medical director for Research Medical Center *[sic]* at that same time. He confirmed that Research Belton Hospital would be the entity deciding whether claimant would serve as an emergency room physician. Dr. Tilson went on to state that emergency room physicians come under the supervision of the hospitals where they work, rather than under the supervision of Coastal. Their continued employment is a determination made by the individual hospitals, rather than Coastal. Dr. Tilson was also working for Coastal when claimant was given his notice at Research Belton Hospital, but he does not recall whether he was the one who gave claimant notice of the termination of the contract or whether that was done by someone else. He went on to state that the independent contractor agreement would be between Coastal and the physician, and between Coastal and the hospital.

Dr. Tilson testified that the provision in the contract where physicians are required to obtain their own continuing medical education is normal under the circumstances.

The Board notes in the initial contract between claimant and Coastal, regular deductions were to be made from claimant's paycheck by Coastal for the purpose of medical malpractice insurance and workers compensation insurance. There is no indication in the record as to whom the workers compensation insurance premiums were paid or if workers compensation insurance was ever actually provided for claimant by any entity.

In workers compensation litigation, it is the claimant's burden to prove his entitlement to benefits by a preponderance of the credible evidence.[7]

The Board will first determine what evidence is in the record for its determination.

Numerous objections were made by the various parties over the records of non-testifying health care providers.

K.S.A. 1991 Supp. 44-519 restricts the reports of health care providers from being considered as competent evidence unless supported by the testimony of the health care provider. Where the testimony is not admissible, then the reports of the health care provider cannot be considered as evidence. However, a testifying physician may consider

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[6] Dr. Tilson in his testimony said Research Medical Center. Research Medical Center is located in Kansas City, Missouri.

[7] K.S.A. 1991 Supp. 44-501 and K.S.A. 1991 Supp. 44-508(g).

medical evidence generated by absent physicians if expressing his or her own opinion, rather than the opinion of the absent physicians.[8] In this instance, numerous medical reports were discussed by the various testifying health care providers, which supported the opinions reached by those health care providers. Regarding the reports themselves, while not admissible unless stipulated to by the parties, the opinions provided by those non-testifying health care providers can nevertheless be considered by the testifying physician when forming his or her own opinions as part of the record.

A medical report generated by K.S.A. 44-516 is subject to a different standard which allows the Director to employ one or more neutral health care providers to make examinations of injured employees as the Director may direct. In this instance, claimant was referred by the Administrative Law Judge to Dr. Lewis for an examination on April 25, 1997. The medical report prepared by Dr. Lewis was provided to the ALJ. Additionally, that medical report was entered into evidence at the time of the regular hearing on August 29, 2000, and also at the deposition of Dr. Clymer on August 20, 2001. In both instances, there were objections made regarding the admissibility of the report.

K.S.A. 44-516, which allows the IME referral, has been in existence for many years. However, effective July 1, 2000, the statute was modified as follows: "The report of any such health care provider shall be considered by the administrative law judge in making the final determination."

The legislature determined in 2000 that the administrative law judge and the Board shall consider reports of independent health care providers who have been appointed under K.S.A. 44-516 by the administrative law judge. The 2000 legislative amendment affects the evidentiary procedure utilized in a workers compensation claim. The amendment does not change the parties' substantive rights or obligations. Therefore, that amendment is procedural and applies retroactively. While the Board notes that the admissibility provision of K.S.A. 44-516 had not been created by the legislature at the time of the examination by Dr. Lewis, it was, however, the law at the time the report was offered both at the regular hearing and at Dr. Clymer's deposition.

The Board determined previously that this is a procedural statute, making retroactivity apply, thereby allowing for the admissibility of such reports.[9] The Board, therefore, finds the report of Dr. Lewis is a part of the record and the opinions expressed by the various health care providers utilizing the other medical reports will be considered,

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[8] *Boeing Military Airplane Co. v. Enloe*, 13 Kan. App. 128, 764 P.2d 462 (1988), *rev. denied* 244 Kan. 736 (1989).

[9] *Daul v. The Jones Store Company*, No. 223,144 & 231,525, 2001 WL 1399430 (Kan. WCAB Oct. 18, 2001), aff'd by the Kansas Court of Appeals in an unpublished opinion, No. 88,007 (Kansas Court of Appeals unpublished opinion, Sept. 27, 2002).

even though those reports beyond Dr. Lewis's report are not admissible absent a stipulation by the parties or the taking of the various health care provider depositions.

The Board will next consider whether claimant's request for benefits is prohibited by K.S.A. 1991 Supp. 44-501(c), as determined by *Boucher.*

The 1991 version of K.S.A. 44-501(c) stated in part,

> Except for liability for medical compensation, as provided for in K.S.A. 44-510 and amendments thereto, the employer shall not be liable under the workers compensation act in respect of any injury which does not disable the employee for a period of at least one week from earning full wages at the work at which the employee is employed.

The Kansas Court of Appeals, in *Boucher*, determined that the claimant in *Boucher* had lost no time from work as a result of the injury. The parties had stipulated to a 9.2 percent permanent partial general disability. However, since the claimant in *Boucher* had missed no work as a result of the injury, the court in *Boucher* denied the claimant any permanent disability beyond medical compensation as there was no loss of wages or compensation to the employee.

In this instance, the Board must deal with two specific issues. First, claimant objects to the raising of the *Boucher* issue, as it was raised neither at the time of the regular hearing nor the time of the pre-hearing settlement conference. Claimant, in his letter of September 6, 2001, objects, noting that until the Tilson deposition was taken on September 6, 2001, this being the last deposition taken by any of the parties with the exception of claimant's discovery deposition of August 29, 2002, and this being the first time that the *Boucher* defense was raised, it was not timely. The Board rejects claimant's argument, finding that even though the *Boucher* defense was not raised until after the regular hearing, claimant had every opportunity to defend on the issue, with the parties allowing the discovery deposition of claimant to be taken over eleven months after the *Boucher* defense was first raised. The Board, therefore, rejects claimant's contention, that the *Boucher* issue should be prohibited from being raised, as untimely.

However, claimant, in his testimony, discussed numerous occasions where he was unable to work as a result of his injuries. In particular, claimant missed a 12-hour shift in Dodge City, Kansas, shortly after the injury, due to ongoing back problems. Additionally, claimant testified at the regular hearing of August 29, 2000, that after the 1991 injury, he

was required to cut his hours back substantially because of back problems.[10] By contract, claimant was required to work from 168 to 192 hours per month if work was available.[11]

K.S.A. 1991 Supp. 44-501(c), in effect at the time of claimant's accident in August of 1991, required that the injury disable the employee for a period of at least one week from earning full wages at the work which the employee was employed. Here, claimant has testified to the hours he was working before the 1991 injury and the fact that he had substantially reduced the hours on more than one occasion after the injury. Claimant's testimony in this matter is uncontradicted. Uncontradicted evidence which is not improbable or unreasonable may not be disregarded unless it is shown to be untrustworthy.[12] The Board finds claimant has proven that he was disabled for a period of at least one week from earning full wages at his employment and, therefore, the *Boucher* defense does not apply in this instance.

Whether claimant is an employee or an independent contractor is a more difficult issue. The contract clearly specifies that claimant was employed as an independent contractor with Coastal. In contract situations, generally the creator of the contract has an advantage over a less skilled person when generating complicated legal documents. However, in this instance claimant was a trained professional, having graduated from law school in 1971, and had been employed as an attorney for several years in Topeka through 1979. Therefore, there was no disappropriate expertise allowing one party an inappropriate advantage over the other. The Board finds claimant was aware of the definition of the term "independent contractor" and entered into the contract with knowledge of and acquiescence to that terminology.

It is often difficult to determine in a given case whether a person is an employee or an independent contractor because there are, in many instances, elements pertaining to both relationships that may occur without being determinative of the actual relationship.[13]

There is no absolute rule for determining whether an individual is an independent contractor or an employee.[14]

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[10] R.H. Trans. (Aug. 29, 2000) at 42.

[11] Cl. Depo. (May 18, 1994) at 41.

[12] *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, 558 P.2d 146 (1976).

[13] *Jones v. City of Dodge City*, 194 Kan. 777, 402 P.2d 108 (1965).

[14] *Wallis v. Secretary of Kans. Dept. of Human Resources*, 236 Kan. 97, 689 P.2d 787 (1984).

The relationship of the parties depends upon all the facts, and the label that they choose to employ is only one of those facts. The terminology used by the parties is not binding when determining whether an individual is an employee or an independent contractor.[15]

The test primarily used by the courts in determining whether the employer-employee relationship exists is whether the employer had the right of control and supervision over the work of the alleged employee and the right to direct the manner in which the work is to be performed, as well as the result that is to be accomplished. It is not the actual interference or exercise of control by the employer, but the existence of the right or authority to interfere or control that renders one a servant, rather than an independent contractor.[16]

In addition to the right to control and the right to discharge the worker, other commonly recognized tests of the independent contractor relationship are:

(1) The existence of a contract to perform a piece of work at a fixed price.

(2) The independent nature of the worker's business or distinct calling.

(3) The employment of assistants and the right to supervise their activities.

(4) The worker's obligation to furnish tools, supplies and materials.

(5) The worker's right to control the progress of the work.

(6) The length of time the worker is employed.

(7) Whether the worker is paid by time or by job.

(8) Whether the work is part of the regular business of the employer.[17]

In this instance, a contract does exist which specifies claimant's obligation to work as an emergency room physician at the facilities contracted by respondent. The businesses, specifically the hospitals where claimant worked, are not connected to respondent except by contract. Respondent itself does not provide emergency room

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[15] *Knoble v. National Carriers, Inc.*, 212 Kan. 331, 510 P.2d 1274 (1973).

[16] *Wallis* at 102 & 103.

[17] *McCubbin v. Walker*, 256 Kan. 276, 886 P.2d 790 (1994).

services, but merely provides the health care providers who work at those facilities. Claimant had the right to employ assistants should he be in a position where he could not fulfil his obligations, with the only stipulation being that any assistant or replacement claimant provided must be licensed to provide the medical care required.

Claimant provided some of his tools, with the hospitals to which he was referred providing the remainder of the tools. In this instance, respondent Coastal provided no tools, supplies or materials. Additionally, Coastal was not in a position to control the progress of claimant's work. As testified by Dr. Tilson, emergency room physicians are an independent lot, generally providing patient care as these physicians so determine. Any restrictions or controls which may be placed on their ongoing activities, as well as the determination whether the health care provider will continue at the various hospitals or be terminated is a determination to be made by the hospitals and not by Coastal.

The Board also finds significant the fact that claimant listed himself as self-employed with the Internal Revenue Service, paying all taxes and also deducting expenses as a self-employed person would.

The Board, in determining all of the factors, has concluded that claimant's relationship with Coastal was that of an independent contractor and not an employer-employee relationship. The ALJ's determination that claimant is not entitled to benefits as a result of that relationship is, therefore, affirmed.

The parties acknowledge that claimant was added as a party respondent on February 19, 1998, when claimant's amended E-1 was filed with the Kansas Division of Workers Compensation. The Board also makes note of the significant fact that deducted from claimant's wages on a regular basis were line items designated as workers compensation and malpractice insurance premiums.[18] While the record clearly delineates the deductions, there is no information in the record to indicate to whom those deducted premiums were paid.

> Each individual employer, partner or self-employed person may elect to bring himself or herself within the provisions of the workmen's compensation act, by securing and keeping insured such liability in accordance with clause (1) of subsection (b) of K.S.A. 44-532. Such insurance coverage shall clearly indicate the intention of the parties to provide coverage for such employee, partner or self-employed person. When such election is made, the insurance carrier or its agent shall cause to be filed with the director a written statement of election to accept thereunder so that such employee, partner or self-employed person is

[18] R.H. Trans., Plaintiff's Ex. 6a, 6b, 6c and 6d.

> treated as an employee for the purposes of the workmen's compensation act pursuant to such election.[19]

Workers compensation premiums were deducted from claimant's paycheck and paid to an unknown entity. This action by claimant in attempting to secure such workers compensation insurance acts as an election under the Workers Compensation Act to bring claimant within the provisions of the Act.

The Workers Compensation Act is to be liberally construed to bring employers and employees within its provisions and protections.[20]

If these payroll deductions were indeed paid to an insurance company of unknown identity, then workers compensation insurance would possibly be available to claimant under the Workers Compensation Act as a self-employed person. Therefore, workers compensation benefits may be available, although the Board is unable to determine from this record from whom these benefits would be paid.

Kansas has applied the doctrine of equitable estoppel in workers compensation proceedings.[21] The Board, in *Kidwell*,[22] was asked to determine whether a respondent should be permitted to deduct monies from a claimant's pay for workers compensation insurance and then deny that the claimant's injury is covered under the Workers Compensation Act.[23]

The Board, in *Kidwell*, held:

> In some states, the purchase of insurance coverage is considered to control or override other factors. *Larson's Workers' Compensation Law*, Sec. 63.04. Such a rule helps bring certainty and assigns responsibility where there will be coverage. The respondent is then estopped from denying claimant was its employee. The parties' agreement is enforced in the workers compensation proceedings. The

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[19] K.S.A. 44-542a (Ensley 1986).

[20] K.S.A. 1991 Supp. 44-501(g).

[21] *Marley v. M. Bruenger & Co., Inc.*, 27 Kan. App. 2d 501, 6 P.3d 421, *rev. denied* 269 Kan. 933 (2000); *Scott v. Wolf Creek Nuclear Operating Corp.*, 23 Kan. App. 2d 156, 928 P.2d 109 (1996).

[22] *Kidwell v. Advanced Home Designs, Inc.*, No. 250,852, 2000 WL 759405 (Kan. WCAB May 31, 2000).

[23] *Stonecipher v. Winn-Rau Corporation*, 218 Kan. 617, 545 P.2d 317 (1976); *see also* 6 Larson's Workers' Compensation Law, § 102.01[4] (2000).

> Board might agree with enforcing a clear promise to provide coverage as an employee.
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> But in this case, it is not clear that respondent was promising to provide workers compensation coverage for claimant as its employee. The written agreements required claimant to purchase workers compensation insurance as a subcontractor and stated claimant would not be covered by respondent's insurance. This portion of the written agreement was verbally modified. Respondent advised claimant that if claimant did not purchase the insurance, respondent would withhold money to purchase insurance. It appears that if respondent purchased insurance it could, and would most consistent with the written agreement, have been for claimant as an independent contractor, either to cover claimant as a self-employed independent contractor pursuant to election under K.S.A. 44-542a or to cover claimant's employees. If the agreement were enforced, claimant would be the one the claim would be against with the claim paid by insurance respondent had paid for out of the money withheld. There is no indication insurance was ever purchased. This leaves a contract question which, as the ALJ pointed out, is outside the Board's jurisdiction. *See*, e.g. *Superior Insurance Company v. Kling*, 327 S.W. 2d 422 (Tex. 1959).[24]

In *Marley*,[25] the Kansas Court of Appeals held the claimant to the terms of a written agreement with the respondent by finding the claimant was estopped from denying he was an independent contractor. In *Newberry,*[26] where the respondent was withholding money from the claimant's pay for the purpose of obtaining workers compensation insurance coverage, the Board found that the fact that the respondent was withholding that money from the pay could result in the respondent being estopped from denying the Workers Compensation Act applied to the claimant's claim. Whether or not there is insurance coverage is a separate contractual question between the respondent and its insurance carrier.[27] In this instance, whether or not there is insurance coverage in existence is a question which must be determined before the Board can rule on whether claimant either has insurance through a unknown carrier or whether respondent should be estopped, under *Marley*, from denying coverage. As the record is incomplete regarding this evidence, the Board is obligated to remand this matter to the ALJ for further proceedings, with instructions that the parties provide information regarding the specific amounts of monies deducted from claimant's pay, designated as workers compensation, and the insurance

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[24] *Kidwell, supra.*

[25] *Marley, supra.*

[26] *Newberry v. LaForge & Budd Construction Company*, No. 250,386, 2002 WL 433110 (Kan. WCAB Feb. 27, 2002).

[27] *American States Ins. Co. v. Hanover Ins. Co.*, 14 Kan. App. 2d 492, 794 P.2d 662 (1990).

company to whom those monies were paid. If information is not available to designate to whom the monies were paid, then respondent is instructed to provide evidence regarding how those deductions were utilized and to whom they were paid or whether they were actually retained by Coastal.

Additionally, pursuant to the stipulation of the parties, the matter is remanded to the ALJ for determination as to whether claimant gave proper notice of the alleged injury to respondent and whether timely claim for compensation was made.

The Board must next consider the nature and extent of claimant's injury.

Claimant was examined by Dr. Clymer on September 28, 1993, with Dr. Clymer reviewing the 1991 CT scan, noting the problems at the L4-5 disc. Dr. Clymer assessed claimant a 3 percent impairment to the body as a whole pursuant to the AMA *Guides* (3rd ed. rev.), which was the appropriate edition to be utilized for a 1991 date of accident, although for a 1991 accident, use of the *Guides* was not required. The record contains several references to subsequent injuries suffered by claimant, specifically in 1994, with regard to his wedding, an encounter with a calf at a rodeo, playing football with his son and a fall at a Pizza Hut. There is also discussion regarding a subsequent automobile accident, although claimant denies suffering any additional problems associated with that automobile accident as it relates to his back. However, the 1994 injuries, according to Dr. Pazell and Dr. Clymer, were sufficiently traumatic to have caused an increase in claimant's symptoms. Likewise, the MRI performed in May of 1994 displayed additional damage to claimant's back, in particular at the L5-S1 level, which did not exist at the time Dr. Clymer examined claimant in 1993. Finally, the examination of Dr. Pazell in 1996 elicited significant symptoms involving claimant's absent ankle reflex, decreased sensation in the S1 dermatome on the left side, with weakness in the foot and ankle, and noted atrophy in the left calf of one inch. None of these symptoms were present at the time claimant was examined by Dr. Clymer in 1993, prior to the intervening injuries.

The Board, therefore, finds that claimant did suffer intervening injury sufficient to relieve Coastal of the obligation of providing additional medical care after Dr. Clymer's examination on September 28, 1993. The Board, therefore, finds any medical treatment or impairments resulting from the subsequent injuries not to have arisen out of and in the course of claimant's employment, but rather are the result of an intervening injury.

The only medical report which determined claimant's functional impairment prior to the intervening injuries is that of Dr. Clymer wherein he assessed claimant a permanent partial disability based upon a 3 percent to the body as a whole. The Board finds that claimant should be awarded a 3 percent impairment to the body as a whole for the injuries suffered on August 8, 1991. However, against whom this award is to be assessed is yet to be determined, as the existence or nonexistence of an ongoing insurance relationship

covering claimant for workers compensation purposes cannot be determined until such time as the additional information ordered be provided upon remand of this matter to the ALJ becomes available.

The Board, therefore, modifies the Award of Administrative Law Judge Robert H. Foerschler of February 16, 2004, to award claimant a 3 percent impairment to the body as a whole for the injuries suffered on August 8, 1991. However, the Award is held in abeyance until such time as the appropriate responsible party can be determined upon remand to the Administrative Law Judge.

This matter is, therefore, remanded to the Administrative Law Judge pursuant to K.S.A. 2003 Supp. 44-551(b)(1) for additional proceedings and orders consistent with the above findings and conclusions.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Award of Administrative Law Judge Robert H. Foerschler dated February 16, 2004, should be, and is hereby, remanded to the Administrative Law Judge for additional proceedings and orders as above ordered.

IT IS SO ORDERED.

Dated this ____ day of February 2005.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

DISSENT

I respectfully disagree with the majority. I believe claimant is an employee for purposes of the Workers Compensation Act. Labeling claimant an independent contractor is disingenuous.

BOARD MEMBER

c: James R. Shetlar, Attorney for Claimant
James K. Blickhan, Attorney for Respondent and its Insurance Carrier (Liberty Mutual)
Katharine M. Collins, Attorney for Respondent and its Insurance Carrier (St. Paul)
Dennis L. Horner, Attorney for Respondents Coastal and Medical Group
John A. Bausch, Attorney for the Fund
Bruce D. Mayfield, Attorney for the Fund
Robert H. Foerschler, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director